

## **Group Disability Proof / Evidence of Insurability Application**

This form is for residents of AL, AK, AZ, AR, CA, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NV, NH, NM, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, & WY.

## Instructions for Employee/Member:

- 1. It is required that you be given the "NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES." Please read it carefully and keep it for your records.
- 2. Please complete Part 2 of the form. **Incomplete information will result in delays.** Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.
- 3. If a question or item of information requested is not applicable, please write in "none" or "no."
- 4. If you make any changes to the application, please initial and date next to the change(s).
- 5. Keep this portion of the form, and be sure to keep a copy of the completed application. Send original completed application to:

Group Insurance Commission Systems Unit P.O. Box 8747 Boston, MA 02114-8747

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Applicant: Please Read & Detach

## NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES

In order to properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers and other insurance companies. In certain instances, we may also need to conduct an investigative consumer report. This usually takes the form of a personal interview that is conducted with you in person or over the telephone. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. All information regarding your insurability will be treated as confidential.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate.

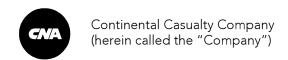
The Company may also make information in its files available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

The Company may make a brief report regarding your insurability to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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## GROUP DISABILITY PROOF/EVIDENCE OF INSURABILITY Form B1-64448-L

Complete ALL information. Incomplete information will result in delays. Type or print clearly with blue or black ink. Forward the original application to the GIC. I. Employer Information LONG TERM Policy Number: SR-83130411 DISABILITY Employer's Name **Employer's Mailing Address** Commonwealth of Massachusetts **Group Insurance Commission** P.O. Box 8747 X Late Enrollee Boston, MA 02114 (TO BE COMPLETED BY EMPLOYEE) **II. Employee Application For Coverage** 1. Employee's Name Gender Date of Birth State of Birth Social Security # Home Phone Residential Street Address State Zip Code Height Weight City In. Lbs. 2. Occupation Work Phone Number Date of Full-Time or Half-Number of hours you are Annual Salary Time Employment schedule to work in a regular workweek? **Duties:** (b) Are you currently performing the duties of your occupation for a regular workweek? (If NO, explain in remarks section below) YES NO 3. (a) What other disability income insurance are you now carrying or have an application or reinstatement pending for? (If none, please indicate) MAXIMUM BENEFIT PERIOD **ELIMINATION PERIOD** BENEFIT AMOUNT(S) ACCIDENT/SICKNESS **COMPANY** ACCIDENT/SICKNESS (b) Have you ever had any disability income insurance postponed, rated, waivered, declined, canceled or had reinstatement refused? If YES, give dates, company name and reason in the remarks section below. ☐YES ☐NO **Remarks:** Questions 2b and 3b (if additional space is needed, use a signed, dated separate sheet.) 4. To the best of your knowledge and belief, have you within the last 10 years been medically treated or medically diagnosed for any of the following: (a) Epilepsy, paralysis, or any nervous, mental or emotional disorder? 

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(i) Alcoholism, drug dependency or substance abuse?				
	d why did you last consult a doct			
	were you told about the findings			
	Treatment and drugs were prescr			
•	ou still under treatment?			
	st of your knowledge and belief, he injuries or check-ups during the			eformity, sickness, 5 or 6?YES NO
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				ce is needed, use a signed, dated separate sheet.)
o. II any an	swer to questions 5, 0 or 7 is 1 is		l <b>owing.</b> (ir additional spa 	le is needed, use a signed, dated separate sneet.)
QUESTIO #	N MEDICAL CONDITION	DATES From – To	RESULTS	DOCTOR OR HOSPITAL NAMES & ADDRESSES
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		_		
belief. I also I AUTHORI company, M as to advice, or mental illi Assurance C	understand and agree that the ins ZE any physician, medical pracedical Information Bureau, consudiagnosis, treatment, or care of an less, and any other non-medical informany, its affiliates, its legal rep	urance applied for, it titioner, hospital, cli mer reporting agency my physical or menta information concerning resentative, or its rei	f issued, shall be subject to inic, other medical or my, employer, or the Veter I condition concerning ming me, to give to the CNA insurers any and all such in	edically related facility, insurance or reinsuring ans Administration, having information available e, including information about drugs, alcoholism A Group Life Assurance Company or Continenta
	Assurance Company or its affiliate			y the Civil Group Elic Association Company of
I UNDERST	AND that any expenses incurred	as a result of a requir	red medical examination	will be borne by the applicant.
	t I may request to receive a cop GREE that this Authorization sha			ppy of this Authorization shall be as valid as the own below.
	LEDGE having received and rean effect for 90 days from the date		ing Medical Information	Bureau. I UNDERSTAND that this application
Date Signed		ignature of Applican	t	

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